11 *Hypnotic Desensitization of the Bowel*

P.J. Whorwell

Hypnosis is the subject of considerable controversy and there is not even a universally agreed definition of what it represents. There are 'state' and 'non-state' theorists, with the former firmly believing that it is some form of altered state of consciousness and the latter not taking such a rigid view (Naish, 1986). Unfortunately, until there is a test or physiological measurement that can confirm or refute its existence the arguments will continue. The situation is further confused by the protagonists of various allied techniques who insist that their method is unique in some way. It would seem much more likely that meditation, yoga, autogenic training, etc. are all variations on a similiar theme rather than being distinct entities. In addition it might be expected that a whole variety of induction techniques, both pleasant and even unpleasant, could result in the induction of the same 'state'. Thus it is possible that phenomena like mass hysteria may form part of the hypnotic spectrum. If the technique is going to be used for therapeutic gain it would seem logical to induce it in a pleasant way. Consequently, hypnotic induction methods usually employ attempts to concentrate the patient's mind on a single concept in combination with suggestions of comfort, relaxation and clam (Waxman, 1989). Our technique as applied to the gastrointestinal system has been described more fully elsewhere (Whorwell, 1987). It is important for all patients to realize that when hypnotized they are not unconscious in any way and are certainly not under the control of the hypnotherapist. I see hypnosis as a self-induced state for which the hypnotherapist is a catalyst. Indeed, the key to the therapeutic use of the technique is that the patient should rapidly learn the art of self-hypnosis.

The hypnosis literature is burdened down by extravagant claims and anecdotal reports on its efficacy in various conditions with hardly any controlled data. However, some observations suggest it has potential that is worthy of further exploration (Black *et al.*, 1963; Fry *et al.*, 1964; Maher-Loughnan, 1970, 1980; Deabler *et al.*, 1973; Clawson & Swade, 1975; Erickson, 1977; De Piano & Salzberg, 1979; Stacher *et al.*, 1980). The technique is only going to become more acceptable if it is subjected to scientific scrutiny and its role in modern medicine more clearly defined.

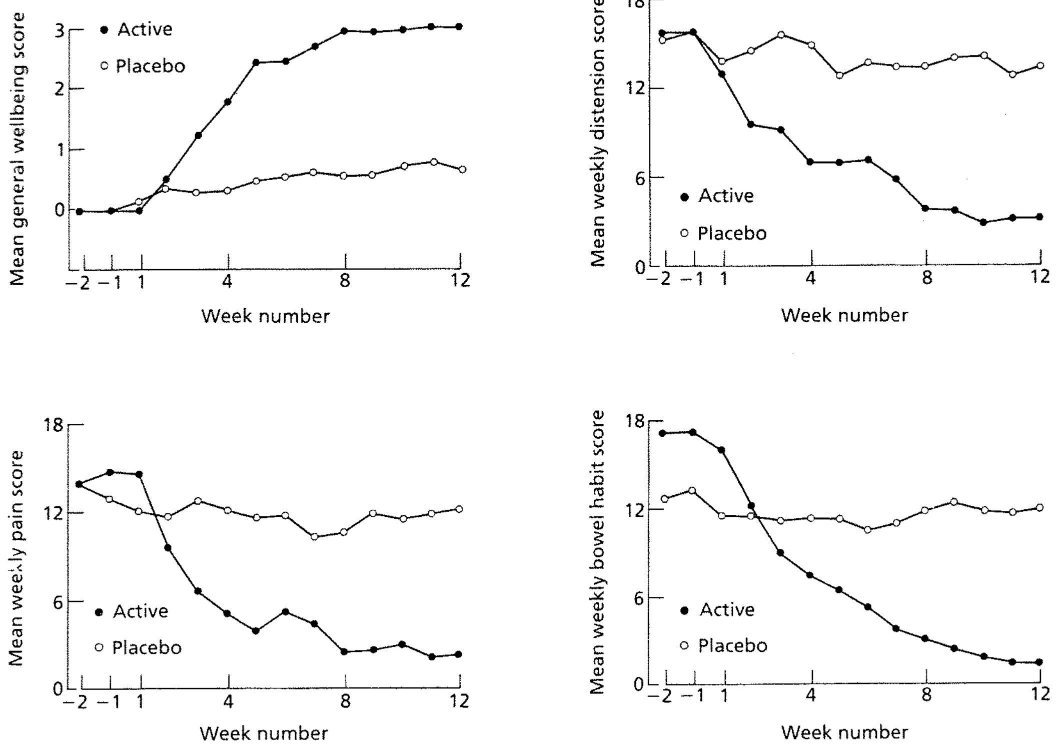

Fig.11.1. Response of patients vs. controls to treatment with hypnotherapy. (Redrawn with permission from *The Lancet*.)

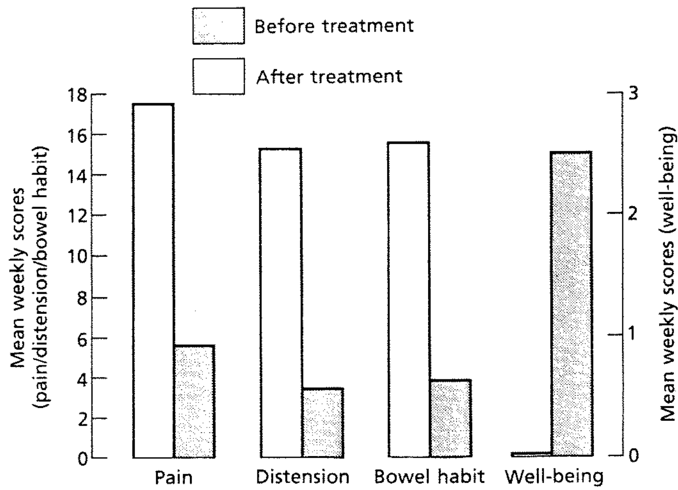

Fig.11.2. Long-term follow-up of 50 patients treated with hypnotherapy. (Redrawn with permission from *Gut*.)

Table 11.1. Results for 50 patients treated with hyphotherapy

	Number	Improved	Not improved
Classic cases	38	36 (95%)	2
Atypical cases	7	3 (43%)	4
Classic cases with psychopathology	5	3 (60%)	2
Total	50	42 (84%)	8
Patients over age 50 from any group	8	2 (25%)	6

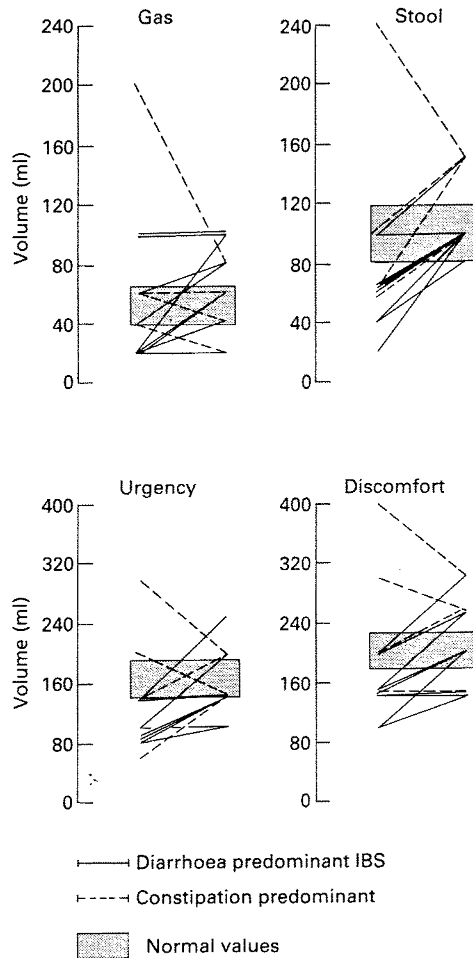

Fig.11.3. Changes in rectal sensitivity following hypnotherapy.

In 1984 we reported the results of a clinical trial of the effect of hypnotherapy in patients with severe refractory irritable bowel syndrome (Whorwell *et al.*, 1984). Thirty patients who had failed to respond to conventional therapy were randomized to two groups,

one of which received a course of hypnotherapy. After 3 months compared with the controls the patients receiving hypnotherapy were much improved with respect to all the symptoms recoded (Fig. 11.1). Further long-term follow-up of the patients demonstrated that the beneficial effect was long-lasting (Whorwell *et al.*, 1987) although some patients appeared to need the occasional top-up session of hypnotherapy (Fig. 11.2). Response to treatment was difficult to predict, but patients in the older age groups, those with psychropathology and patients with atypical IBS seemed to do less well (Table 11.1). Recently Harvey *et al.*, (1989) have independently confirmed our encouraging results and have also suggested that group therapy may be a practical proposition.

The mechanism by which hypnotherapy could be helping patients is speculative but is likely to be by a number of different mechanisms. For instance it probably reduces stress levels and increases coping ability. It is also possible that it might actually lead to some modification of gut responsiveness and we have recently reported a study that supports this view. Patients undergoing hypnotherapy for IBS were subjected to anorectal manometric assessment both before and after a course of therapy (Prior *et al.*, 1988a). Patients with visceral hypersensitivity (Prior *et al.*, 1988b) showed a significant reduction in this abnormality, whereas in those subjects with hyposensitivity there was a tendency to change in the opposite direction (Fig. 11.3).

As hypnotherapy is so time consuming it is at present only possible to offer treatment to subjects with severe refractory symptoms. However, this drawback may be overcome by the technique being made more widely available and the by use of group therapy. Investigation of the mechanism of action of hypnotherapy may not only increase its acceptability but also lead to new insights in the understanding of the pathophysiology of IBS.

REFERENCES

Black, S., Humphrey, J.H. & Niven, J.S.F. (1963) Inhibition of Mantoux reaction by direct suggestion under hypnosis. *Br Med J* **1**, 1649–1651.

Clawson, T.A. & Swade, R.H. (1975) The hypnotic control of blood flow and pain. *Am J Clin Hypn* 17, 160–169.

De Piano, F.P. & Salzberg, H.C. (1979) Clinical applications of hypnosis in three psychosomatic disorders. *Psychol Bull* **86**, 1223–1235.

Deabler, H.L., Fidel, E., Dillenkoffer, R.L. & Eider, S.T. (1973) The use of relaxation and hypnosis in lowering high blood pressure. *Am J Clin Hypn* **16**, 75–83.

Erickson, M.H. (1977) Control of physiological functions by hypnosis. *Am J Clin Hypn* 20, 8–19.

Fry, L., Mason, A.A. & Pearson, R.S. (1964) Effect of hypnosis on allergic skin responses in asthma and hay fever. *Br Med J* **1**, 1145–1148.

Harvey, R.F., Gunary, R.M., Hinton, R.A. & Barry, R.E. (1989) Individual and group hypnotherapy in the treatment of refractory IBS. *Lancet* **1**, 424–425.

Maher-Loughnan, G.P. (1970) Hypnosis and autohypnosis for the treatment of asthma. *Int J Clin Exp Hypn* **12**, 1–14.

Maher-Loughnan, G.P. (1980) Clinical applications of hypnosis in medicine. *Br J Hosp Med* 23, 447–455.

Naish, P.L.N. (1986) *What is Hypnosis—Current Theories and Research*. Open University Press, Milton Keynes.

Prior, A., Colgan, S.M. & Whorwell, P.J. (1988a) Changes in rectal sensitivity following hypnotherapy for irritable bowel syndrome. *Gut* (in press).

Prior, A., Maxton, D.G. & Whorwell, P.J. (1988b) Anorectal manometry in IBS: differences between diarrhoea- and constipation-predominant subjects. *Gut* (in press).

Stacher, G., Berner, P., Naske, R. *et al.*, (1980) Effect of hypnotic suggestion of relaxation on basal and betazole-stimulated gastric acid secretion. *Dig Dis Sci* 25, 404–413.

Waxman, W. (ed) (1989) *Hartland's Medical and Dental Hypnosis*, 3rd edn. Baillière Tindall, London.

Whorwell, P.J. (1987) Hypnotherapy in the irritable bowel syndrome. *Stress Med* 1987, 5–7.

Whorwell, P.J., Prior, A. & Faragher, E.B. (1984) Controlled trial of hypnotherapy in the treatment of severe refractory irritable bowel syndrome. *Lancet* 2, 1232–1234.

Whorwell, P.J. Prior, A. & Colgan, S.M. (1987) Hypnotherapy of severe irritable bowel syndrome: further experience. *Gut* 28, 423–425.